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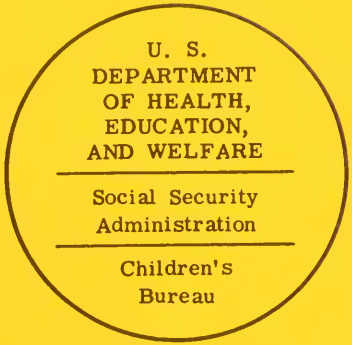

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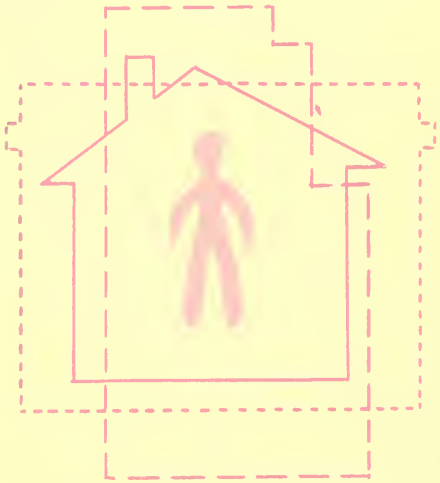
child-caring institutions

their new role in community development of services



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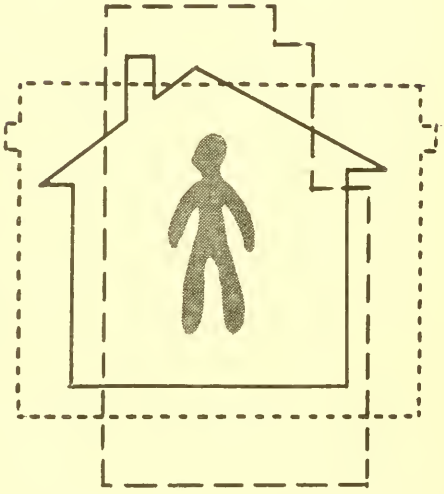

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foreword

A CHILD who is forced to leave his family and live with strangers rouses the concern of society as well as that of parents, child-caring agencies, and institutions. Among such children are a quarter-million youngsters living in child-caring institutions over the country. These are neglected, dependent, disturbed, delinquent, and retarded children.

It takes much wisdom for a parent to rear a child well and help him grow. It takes much more wisdom for an institution to help someone else's child develop properly. So often the child comes with anxiety, a sense of loss, and perhaps with outright bitterness. To win his confidence, to help him grow and develop as he should, and to restore him to family living—these are real challenges to an institution's board, executive, and staff.

For the community, there is a parallel challenge. It is the difficult job of locating troubled children and providing them with the appropriate kind of care they need whether in their own homes, in foster families, in institutions, or elsewhere. In a sense, providing help for just one such child is intermeshed with broader community planning for all children.

Both the community and the institution are the audience for this publication. For the community it presents ways of identifying, studying, and serving children. For the institution it suggests ways of improving its role and use in a total community effort. Changing conditions and services affecting families, the new and old groups of children requiring care, and the effects of all these changes on institutions are considered.

The Children's Bureau believes that this publication can serve as a useful background and guide for board members and professional staffs of institutions and agencies as well as for community planning groups, legislators, and judges. Each affects and depends upon the other in their common purpose of promoting a good life for children.

Katherine B. Oettinger

KATHERINE B. OETTINGER
Chief, Children's Bureau

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child-caring institutions

their new role in community development of services

FOR TWO CENTURIES now, child-caring institutions have helped families in caring for their children. Every generation brings its toll of dependent, neglected, disturbed, delinquent, and mentally retarded youngsters to institutional doors.

Some surprising changes have occurred in family and community life in the last few decades. Social, economic, and medical advances have reduced the proportion of families needing foster care for their children. Clinic, court, and agency services have appeared in many communities to help families care for their troubled children in their own homes.

These changes have led to changes for child-caring institutions, too. New groups of children are being referred with new needs, and different tools are needed to care for them properly. All of this has brought many questions from institutions, referring agencies, courts, clinics, and from community planning groups. How do we differentiate now between the child who can be helped at home, in a foster family, or an institution? What kinds of children need modern institutional care? What goes into such care? Are there guides for developing total community services on a long-range and immediate basis?

This document does not offer "head-on" answers to all these questions for individual communities or institutions. But it does attempt to identify major changes affecting families, and principles that might guide communities and institutions in developing services for children. It recognizes that the right kind of institutions are an indispensable part of child-caring services.

As used in this document, an "institution" refers to a 24-hour resident group-care facility which is operated by an individual, organ-

ization or agency. It may be serving dependent, neglected, delinquent, disturbed, or retarded youngsters under public or voluntary auspices. Some of these institutions may be small "group homes" serving as few as 7 or 8 children. At the other extreme are large establishments serving close to a thousand youngsters. They are administered by social welfare, health, and mental health agencies, boards of control, voluntary lay boards, and other groups.[1]

institutions: a citizen response to children in need

Most child-caring institutions emerge as a form of cooperative citizen action to meet the immediate needs of certain groups of children in the community. Back of such cooperative action often lies the concern and interest of a single individual—a parent with a troubled child, a professional person engaged in helping children, or an interested layman. On rare occasions an individual benefactor empowers a board of trustees to establish an institution for a specific group of children, such as "poor white fatherless boys." More often the individual promotes his interest through associates, sectarian or fraternal groups, or other agencies and organizations. Or he may try to interest other citizens in urging legislators to enact laws and to appropriate money for a public institution.

Form and functions differ

A multitude of motives may press toward the creation of an institution. Each emerges from a different complex of reasons, impulses, philosophy, and technical knowledge on the care of children. No wonder institutions vary so from community to community. For example, an institution in New York City rents a five-bedroom apart-

[1] This document excludes residential schools, convalescent homes, hospitals, and other medical facilities for physically handicapped children. The terms "dependent," "neglected," "delinquent," "disturbed," and "retarded" are used in a generalized, descriptive way. The terms are not diagnostic, nor a basis for planning treatment for an individual child. Some children have combinations of problems. Others are categorized on circumstantial rather than diagnostic bases. Furthermore, there is a wide range of mild, moderate, and serious problems within each category.

ment as a group home for 12 adolescent girls and a housemother because these girls need to be part of a community. In contrast, a fraternal group places girls of these same ages in an institution that serves almost 1,000 children. Or, again, 12 emotionally disturbed children receive individualized clinical care in a specially designed children's treatment center in Cincinnati, while in other communities such children are in public mental hospitals living with adult patients (18).

Thus, what happens "for the good of children" depends on where a child lives, the people who organize services in his behalf, the resources that prevail when an institution is established—and, most important subsequently, the capacity of the institution to respond vigorously to new conditions, knowledge, and resources.

Family and community conditions change

Many changes in the last fifty years have profoundly affected children, their families, and the ways in which communities help children. Among these are: Fewer deaths among parents of young children. . . . Improved economic conditions and assistance programs for parents. . . . Deeper understanding of family ties for children. . . . Research discoveries of emotional damage to infants and preschool children reared in hospitals and institutions. . . . Children are reached earlier in their own homes through local community resources.

The effects of these changes come slowly for some programs and in some communities but quickly in others. For example, programs for dependent children have been affected more rapidly than other programs. Although there is great increase in the total number of children in our country, the incidence of full orphans in the population has dropped to one tenth of one percent (27, p. 17). More paternal half orphans are able to remain at home because of public assistance and insurance programs (27, p. 18). Child welfare services to dependent children in their own homes and foster family homes are expanding and many of the children formerly found in institutions are remaining in their own homes or are in foster family care. The rapidity of these changes is reflected in the decreased numbers of dependent children in institutional care. In December 1933, about 140,000 children were in institutions (5, p. 4). By 1950, the population had dropped to about 95,000 children (6, p. 18). In the same interval, children in foster family homes increased by 60,000.[2]

[2] Estimate made by Division of Research of the Children's Bureau.

In other child-caring programs more youngsters are being served in the community than in institutions:

> For example, about 95,000 delinquent children are under care of probation officers in their community,[3] compared to some 40,000 in training schools (6, p. 18). At least 125,000 emotionally disturbed children are served annually in out-patient clinics[4] as compared to some 13,000 served in children's residential treatment centers and public and private adult mental hospitals.[5]
>
> Over 150,000 mildly and moderately retarded children are served in special school classes, day care, diagnostic and counseling facilities as compared to the 46,000 (6, p. 19) served on a given day in institutions. (Public education special classes alone were serving 113,500 during 1952–53.) (23, p. 9)

These community resources are absorbing larger and larger numbers of younger, less disturbed, or less retarded children who can be cared for while living at home or in foster homes. In turn, this means that the more severely disturbed, aggressive delinquent, and severely retarded children are squeezed to the top and referred to institutions. Since these children have more complex treatment needs, institutions are being asked to provide more specialized care and treatment.

Conversely, as the quality of the treatment in institutions improves, more children become ready for return to their own communities and the institution presses community agencies and organizations to provide adequate aftercare through counseling, clinical, vocational guidance, foster family, and other services.

What is becoming increasingly clear to the community and institution alike is that over a period of time no child-caring service can exist alone or unchanged and serve children well. Each service must be capable of adapting to changing conditions, knowledge, needs, and resources. As one administrator phrased it:

> ". . . In recent years, there has been a marked change in the population of our Children's Home. Today's children are referred to us for other reasons than those found years ago. Family tensions have increased, more mothers work, divorce rates are high, and the whole structure of both family and community has undergone terrific change, with the result that we have many maladjusted children. Today's institution needs trained, understanding personnel to help this group of children, and we

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[3] Estimate made by the Division of Research of the Children's Bureau.

[4] Estimate made by National Institute of Mental Health.

[5] Preliminary unpublished data from the Bureau of the Census, March 1953.

believe that specific, remedial methods must be developed to help each child. . ." (30, p. 2)

new patterns in community services

What are the new patterns of service emerging in communities? More communities are looking at unserved children and are exploring ways of helping them. Parents are promoting services for retarded and disturbed children and agencies are encouraging them to use help for themselves in order to help their children. Casework and clinical services are in greater demand. Casefinding and "reaching out" services are expanding. School social work is being strengthened (28). Communities are seeing community diagnosis and treatment as basic to total program development for any group of children. More money, more research, and wider public understanding are crucial in the new patterns of helping.

Diagnostic evaluation

Perhaps fundamental to all these changes is a push toward more adequate diagnostic evaluation of a child's difficulties by community agencies before treatment of any kind is initiated.

Not too long ago some psychiatrists, pediatricians, social workers, and judges were recommending commitment of children to institutions on such presumptuous terms as these:

> "This boy is delinquent, has repeatedly stolen, and needs to be placed in a controlled environment."
>
> "I am sorry to say your child is defective. As your physician, I advise you to place him in an institution."
>
> "Mary is neglected and living in bad home conditions. She needs to be removed and placed in the State Home immediately."
>
> "This child is emotionally disturbed and needs institutionalization."

This kind of prescription was alarming because it stereotyped children and ignored their real needs. What was equally distressing

was that most of these persons never saw the institution to which they committed the child.

Unfortunately, in some localities such practices are still with us. Several States send dependent and delinquent children to the same "correctional institution." Numerous courts have no professional help in deciding what to do for Johnny or Mary. Child-placing or counseling agencies are struggling to recruit trained workers. Parents of disturbed or retarded children spend days trying to get more adequate diagnosis and help for their child—rather than "rubber stamp cliches." A recent conference on research in the children's field expressed its concern with categorical stereotypes in this way:

> ". . . when more adequate diagnostic categories have been developed, when elements in the controlled environment are more adequately understood, and when methods of evaluation have been developed and tested . . . we may with considerable confidence place children having certain kinds of difficulty in settings in which tested experience indicates that their chances for progress are best." (14, p. 274)

The shortage of funds, staff, and tested principles to guide us in work with children is undeniable. Nevertheless, the steady move among community agencies toward more adequate diagnostic evaluation should eventually provide a better base for formulating concepts, testing practice, and wise use of staff and funds in the adequate care and treatment of children. Although this conviction about the basic importance of adequate diagnosis is only an intellectual agreement in some agencies, it has already been translated into action in others.

What are some of the changes in diagnostic practices that are occurring? Helen Perlman has phrased it for us:

> ". . . our tendency to assume that to classify material or persons is to know them. Or that to put a person and his problem into a ready diagnostic category is to understand him. But this is a gross fallacy. The fact is that classification is but the preliminary 'roughing out of diagnosis.' The person's particular, specific nature must still be divined within the classification; his differences from others of his kind must still be sought out." (24, p. 33)

Fortunately, signs of deeper, differentiated, and wider activity in diagnostic evaluation can be seen everywhere: deeper in the sense of agencies looking more thoughtfully at causes of behavior; differentiated in workers recognizing that two children with the same symptoms have different treatment needs; wider in agencies recognizing that adequate diagnosis must include family, community, and agency resources along with study of the child. Six elements im-

portant in diagnosis are appearing with great frequency (15), (3), (7).

1. Interdisciplinary evaluation of the child's condition, his behavior, and its possible causes, his strengths, desires and needs.
2. Evaluation of the family situation, attitudes, role, and potentials for helping.
3. Evaluation of community attitudes and group influences.
4. Appraisal of agency adequacy or inadequacy in helping to meet the child and family's needs and the community situation.
5. Familiarity with community resources, foster family, and institutional resources.
6. Matching the child and family's needs with the most appropriate treatment resources; and identifying and developing the needed but lacking resource.

The child's needs and desires

Agencies are learning how to work more clearly with the child's own desires and needs. These are almost the touchstone for the New Jersey Department of Institutions and Agencies experiment with a small institution for delinquent adolescents. This institution offers young people opportunities for guided group discussion, for self understanding and for trying out more constructive and satisfying ways of handling their personal problems. The assumption is that these adolescents must somehow become aware that many of their difficulties are "related to motives and patterns of perception" within themselves (13, p. 11). They must be helped to take the initiative in working toward change and growth within themselves, instead of continuously blaming their families, communities, and the law.

The parents' role

The agency's evaluation of family strengths and attitudes is equally important in the interest of the child. Instead of psychologically fencing out the parent, agencies encourage parents to have a part in helping the child. Through the worker's skill in helping parents in behalf of the child, some parental attitudes can be altered, parent-child relationships rebuilt, and parents restored to their capacities to continue parental responsibilities. Vincentz Cianci (10), for example, discovered that many families requesting institutional placement for their mentally retarded children withdrew their applications

when they had educational and counseling help. A child-placing agency goes further in its belief that:

> "Even when it is decided that the family situation is predominantly injurious to the child and that the child cannot be treated in his own home, two additional questions must be considered—(a) Is there a foster family available that can care for the child in such a way as to improve the situation? (b) Can the child and his parents be helped by placing him?" (19, p. 74)

Those probation services for delinquent youngsters which place a heavy burden of proof on the probation officer who is recommending removal of the child from his home, are stressing the importance of trying to help children in their own family. No doubt in doing this, some children may be kept in their own homes too long, but unfortunate as these mistakes in judgment will be, they cannot compare with the heavy toll in well-being associated with the hasty removal of children from their own families during the last half century.

Community influences

Agencies are also trying to evaluate local community attitudes and group influence on the child's development, and ways of working with groups to benefit children. Some social handicaps, such as some forms of delinquent development can be understood more clearly in relation to the community or group forces which helped to mold the pattern (11). Treatment cannot ignore these influences. Treatment, as a matter of fact, must constructively utilize these group forces for example in the way agencies are reaching teen-agers in high delinquency areas through group-work methods (36).

Courts, clinics, and referring agencies are beginning to use foster family and institutional resources with more discrimination.

Foster family care

Foster family care is serving over 180,000 neglected and dependent children, but as yet is used relatively less for delinquent, disturbed, and retarded children. Why this is so becomes clear as we examine the nature of foster family care.

A foster family home is a cultural unit, located in a community, and relying heavily on local community resources for itself and for the foster child. The foster family is chosen because its emotional patterns appear to carry some therapeutic value for a particular child. The family is not expected to drastically reorganize these patterns in order to meet the needs of the child placed in the home. Nor can

the tolerance threshold of the neighborhood for certain misbehavior on the part of children be stretched too far beyond its normal limits.

Such families are increasingly used for neglected and dependent infants, toddlers, preschool (4, p. 153) and grade-school youngsters. These are children with emotional patterns and needs acceptable to foster parents and, in some measure, responsive to the patterns of the foster family. Some of these "ordinary" foster families do wonderful jobs with children with mild physical, mental, or emotional difficulties. On occasions, too, youngsters with severe problems somehow get what they need from certain foster families without too much casework or clinical help.

Unfortunately, in some communities with inadequate diagnostic evaluation of children's difficulties, too often foster family care is used in a stereotyped way, routinely, and without real sensitivity to matching the child's need and patterns with foster family patterns. Some disturbed children tend to be moved time and again from one foster home to another finally landing in an institution.

> For example, six-year-old Tommy was removed from his own home after his father had kicked him in the mouth so violently that he knocked out Tommy's front teeth. His mother was severely retarded and irresponsible. Tommy's behavior swung from panic in his father's presence, to hostile rages with his mother, to physical punishment of other children in the neighborhood. Foster families found Tommy's behavior unbearable after a few weeks. Eventually he was referred to an institution.

For use with some of these youngsters, a few agencies are now experimenting with "specialized" foster homes, with foster parents (35), (37) carefully selected for their capacity for understanding and caring for a particular child, for cooperating with agency caseworkers and clinical staff, and for their capacity to handle constructively their own emotional patterns in response to the child's needs.

Agencies are learning to be more skillful with parents who object to foster family care of their children because they see it as a threat to their own parental identity. Often parents can be reassured about the importance of their role for their child and, at the same time, recognize the helpfulness for foster parents in temporarily meeting the needs of their child. These agencies are improving their foster family care through homemaker services, use of local public health nursing, and clinical services.

Matching needs with resources

Unfortunately, for the child who must live away from his home, at least temporarily, the criteria used by agencies in deciding

between foster family and institutional care are still fuzzy. Some agencies try all children in foster families first, and then place those who fail to adjust to a foster family in institutions; some agencies use age as their major criteria; some feel the "full orphan," the "responsive child," the child whose parent prefers foster family care—are the best prospects for such care. Some believe that a child with several siblings, with unsocialized behavior, with predominant rejection of family life—is not appropriate for foster family care and better off in an institution. Some agencies must use institutions because foster homes are not available or because foster home finding agencies will not accept certain kinds of children.

A small number of agencies are uneasy in using such isolated factors and instead prefer to use foster family care when the following conditions predominate in the diagnostic evaluation:

1. The child's development can be strengthened by close, personal relationships in a constructive substitute family, located in a favorable school and neighborhood setting.

2. Both the child and his parents are predominately cooperative toward the plan to use foster family care. "Engaging the parent and the child in this way helps both enter into the plan more positively and contributes to the success of the placement." (17, p. 71)

3. The child's behavior or condition can be tolerated in the community as well as in the foster family.

4. The foster family has psychological patterns which seem favorable for strengthening the child's development; and for enhancing the child's relationship to his own parents. The foster family's own psychological needs are sufficiently satisfied to insure some continuity in the child's care; the foster family has a capacity for using the agency worker's guidance.

5. The agency worker has sufficient time, and professional skill to support the placement soundly.

Along with the expansion of foster family services for some children, there has been a widespread development of other community-based services for retarded and disturbed children such as diagnostic and treatment clinics, special classes, therapeutic nursery groups, discussion groups for parents, day-care centers, homemaker services, etc. Neglectful parents are given help through casework and other services. For all children, communities are gradually pulling together health, including mental health, and child and family services.

Thus, the first line of protection and care is now vested in community agencies serving the child in his own home. This protec-

tion includes earlier discovery of troubled children, sounder diagnosis of need, and sounder choice of alternatives in treatment for the child and his family.

At the present time, though, courts, clinics, and agencies seldom have an ideal choice of resources for a specific child. Usually the best choice represents the best compromise between what is desirable and what is available. A pre-psychotic girl of 7 may need unusual understanding and helpful foster parents, plus clinic services, plus counseling for her own parents. In one community she may get close to the ideal combination. In another, she may be placed in an institution for dependent youngsters, or in a State mental hospital. In still another the child may be kept at home with no service of any kind.

new demands on institutions

In line with all these changes—changes in conditions, knowledge and resources—communities are making new demands upon child-caring institutions.

Different children require care

Institutions with a tradition of serving "normal" infants, toddlers, and school-age dependent children are being urged to provide shorter term, more specialized care for older children, and mildly or moderately disturbed children. Institutions for retarded youngsters find their populations containing more severely retarded children (26, p. 372) and many with concomitants of physical handicap (31, p. 95). Residential treatment centers for disturbed children report communities are urging them to accept the more severely disturbed children. Training schools for delinquent youngsters are having the more aggressive, more disturbed child and a growing fringe of retarded delinquent youngsters committed to their care. "We don't get the kind of children we used to," is a characteristic observation of many child-caring institutions.

These new demands on institutions are reflected in the findings of many community surveys of unmet need. A New York City survey points out the need for good quality institutional care for adolescents

from 13 through 15—"many are emotionally disturbed." Boston mentions seriously disturbed children and adolescents as needing institutional care. Michigan reports psychotic children, teen-age children with behavior problems, children needing emergency shelter, and certain "mentally defective children" as requiring institutional care of good quality. New Jersey reports a number of children needing psychiatric study homes. St. Louis County, Missouri identifies some children in the following groups as in need of good institutional care—adolescent boys and girls, children needing emergency care, mentally retarded children, and children with emotional problems. Summit County, Ohio (9, p. 15) reports that ". . . a prime unmet need in the county's handling of unfortunate children is the need for a place where emotionally disturbed children can be cared for and treated. At present many such children are placed under detention in the Detention Home." It must be kept in mind, however, that in some communities inadequate or insufficient diagnostic and community treatment resources are the real reasons why more institutional care is being sought.

These new referral demands on institutions can be summarized along three lines:

1. Institutions are being asked increasingly to serve the child who needs to be removed from community living because his behavior or condition is, at the moment, not treatable or tolerable in the home, foster home, or community—even when maximum use is made of community resources in his behalf.

2. In order to properly serve these children, institutions are being asked to provide individualized professional services integrated with more constructive group influences—and both closely related to what the child needs, and what is happening in his family.

3. In addition, institutions continue to be used for some dependent children who resist living with foster families for a variety of reasons including close attachment to their own parents, distrust of dependent relationships with any parent persons, etc.

   Similarly, some parents reject foster family care for their child because it threatens their own parental role (e. g., "I won't risk having any family take my child away from me psychologically."). This attitude may persist even with casework interpretation and reassurance.

Care depends on community resources

These new demands reflect communities on the move in developing local services. They are not characteristic of communities in

which services are static and a great proportion and range of children are sent for generalized institutional care. In static communities many dependent, mildly retarded, or mildly disturbed children find their way into an institution on a default basis. Diagnostic evaluation is lacking. "The institution has to stand by and take responsibility for many children preferably cared for in other ways but for whom communities have not yet developed the more appropriate services." (29, p. 1) However, such "stand by" institutions are recognizing they need casework and improved group care, too.

three levels of quality

Unfortunately, many of our child-caring institutions still concentrate on shelter, on custody, and on the child's adjustment to the institution's general patterns and routines. Many of these institutions are isolated functionally and geographically from other child-caring services. Often they lack an understanding of children as individuals, and as a result there is little coordination of care among various staff members. Casework and clinical services are missing. Little or no casework counseling is offered to parents while the child is in residence. Cottage personnel or houseparent staff have little orientation to mental health concepts and tend to be helpful with some children but destructive with others, particularly children they do not understand or whose behavior irritates them. Intake is primarily an effort to identify children who can adjust to the institution's program.

A smaller number of institutions are looking more sharply at children's needs with the help of caseworkers (16). They are moving from long-term custodial care to shorter, planned, purposeful care. These institutions try to modify or adjust their programs to meet the needs of individual children within the group setting. Some group work and clinical services are being added. Work with parents is included. Houseparents in these institutions, though untrained or partially trained, gain mental health and other treatment orientations through in-service training and supervised experience. Some effort is made to pool all staff thinking in diagnostic conferences. The in-

stitution also is relating its program to community needs and community services. Most of these institutions depend on community resources for some of their services (educational, nursing, medical, psychological, or psychiatric services). Some are purchasing or renting decentralized group homes for groups of children who need closer community living.

Then, a still smaller number of institutions concentrate on comprehensive treatment of disturbed (25), delinquent (21), or retarded children (31). These institutions strive to coordinate all individual and group services for the child and his parents. This coordination evolves from careful intake screening, full diagnostic study of child and family, and staff consensus both on the over-all treatment plan and on the specific role each staff member plays in this plan. Part-time or full-time psychiatrists increasingly help in guiding treatment. This further strengthens the total treatment approach in the institution especially the efforts of houseparents or cottage personnel who need to have a sound grasp of mental health concepts. Many houseparents are beginning to absorb these concepts through staff conferences, seminars, individual supervision, and consultation. As a result they are learning how to use themselves in different ways with children who have different needs. They are developing skills in working with casework and clinical personnel, and in using the cottage and other groups to help individual children. Professional groupworkers are being added to this team (20). They are helping to redesign the setting for group living, developing enriched cottage life, supervising cottage personnel, and participating in group therapy experiments. Remedial education, psychological and pediatric services complete the total program approach.

These "treatment" institutions may provide all the services children require on their own campus or they may use a combination of on-campus and community services in the various stages of the child's treatment. When necessary, they provide maximum security for the child, the institution, and the community against the destructive, assaultive, or otherwise dangerous child whose own inner controls are poorly developed. These institutions are especially valuable for those children who must be removed from the community and have aspects of their daily living and treatment coordinated. These institutions include children who are extremely destructive, homicidal, suicidal, or sexually delinquent. They are useful for children with complicated behavior patterns who need round-the-clock observation, understanding, and treatment. They are perhaps our best resource for learning to help children who come with combinations of physical handicaps, mental retardation, and emotional disorders.

These institutions take advantage of the best modern knowl-

edge and practice in helping children in residential settings. They are alert to changing needs and resources in the community and use them intelligently to promote the treatment of children. They tend to be closely coordinated or merged with community child-caring agencies, clinics, and hospitals, and out-patient resources. They are concerned about research, especially ways of evaluating treatment results.

Realistically, communities will have institutions varying in quality for many decades to come. But, the community bears the heavy burden for improving its local community resources which in turn improve the use and quality of these institutions. The institution has its own responsibility not only for sharing in promoting community services but for promoting its own role and services.

Twenty marks of a good institution

■ 1. *The institution is moving from isolation toward cooperation, coordination, and even merger with community agencies serving the same general group of children.* It recognizes that a child is served best when a variety of services are available to match his needs. It sees the inadequacy of an institution offering only one service without close referral to other services. It may develop its own good quality adoption, foster family, and service to children in their own homes—when these are not available in the community.

■ 2. *The institution's executive, board members, and staff are active on community councils, planning groups, and interagency conferences.* Instead of complaining that community projects are developed without them, they are identified as "people who care about children" and want to share in total community development of services for them.

■ 3. *Not only is the institution going out into the community but the community is coming into the institution.* It opens its doors to parents, volunteers, and local citizens. ". . . It pours in so many volunteers, ideas, funds and services, that in a real sense the institution becomes part of the community." (8, p. 155)

■ 4. *Sponsors of the institution remember it was created in response to immediate community needs and must remain responsive to new needs as these arise.* Therefore, the institution is vitally interested in what happens to children it turns away, to children remaining in shelters and detention homes, and to other unserved children in the community.

■ 5. *The institution is willing to experiment with service to the group in the community most in need of this type of care.* It may begin with a few selected cases that can be absorbed along with the current function.

It may establish new units, group homes, or other resources—if the new service is incompatible with the old.

■ 6. *The institution continually expands its use of related community child-caring resources.* It becomes clearer about which disturbed child can be referred to the local child guidance clinic, which dependent child can be served through public or voluntary child welfare services, which retarded child can be served in his own home.

■ 7. *The institution is expanding from a service to the individual child, toward concurrent casework service to parents, training of personnel, evaluation of treatment methods, and cooperating in basic research.*

■ 8. *Children accepted for residential care are increasingly those children requiring temporary separation from families or foster families, who need individual and group treatment programs on a coordinated base.* These children cannot be treated in the community by other community resources. If the institution accepts children because a more appropriate community resource is missing, this must be pointed out to related agencies, courts, the public, and to planning groups.

■ 9. *The treatment needs of children increasingly influence administrative planning such as selection of staff, grouping of children, and developing of services in the institution.* In other words, the entire environment of the residential setting is constantly adapted to the treatment requirements of the child and the group.

■ 10. *Administrative, psychiatric, pediatric, casework, nursing, medical, group living, group therapy, psychological, and educational staffs are guided by an understanding of the mental health processes involved in the treatment of children and their families.*

■ 11. *A "masterplan" for the study and treatment of the child and concurrent service to the family is established before or soon after his admission and is frequently reviewed and reshaped during his residence.*

■ 12. *This diagnostic and treatment plan evolves from the joint thinking of all staff members who are treating the child and working with the parents.* It is not a simple prescription given to the residential staff by the psychiatric, medical, or casework staff. Moreover, procedures are established to coordinate effectively the activity of various staff members for the benefit of the child and his parents at various stages of the child's treatment. A clear differentiation is made in the role of the institutional caseworker and the community agency caseworker. The institutional caseworker must keep in close touch with the community caseworker who is seeing the child's family.

Changes in family conditions and attitude can have major influence on the child's need for resident care.

■ 13. *Each staff member becomes a part of a total effort in behalf of the child.* He shares his observations and thoughts about the best over-all care or treatment plan for the child. The houseparent, caseworker, group-worker, psychiatrist, or other member of the staff then derives his own role and approach to the child from this agreed upon over-all plan. On occasion he may find the plan questionable or find himself unable or unwilling to carry out his part of the plan. In the interest of the child, he then brings his questions or concerns to a staff discussion. With such a philosophy of helping, there is little staff rivalry, undercutting, or competing for favorable response from the child.

■ 14. *The grouping and interaction of children is used constructively and not left to chance.* Groups are becoming smaller and a tolerance for emotional deviation is developed within individual children. Group activities which promote status, the formation of subgroups, the effects of leadership, and the effect of group contagion are constantly and actively scrutinized for their impact on individual children. The interdependence of individual and group therapy is recognized and utilized. For example, the decision to admit a child into the institution is based not only on the child's own behavior, his treatment needs, and his family situation, but also on his potential impact on the group of children and on the staff, and likewise their impact on the child, both individually and as a household. Experiments are tried in grouping children according to their treatment needs, instead of by similar age or behavior. One residential treatment program on the west coast, for example, has successfully grouped for treatment purposes emotionally disturbed children ranging in age from three to eighteen years.

■ 15. *Group living is well-rounded, flexible, and appropriate for the age and needs of youngsters in residence.* There is richness in human and activity resources for restoring youngsters' capacities to relate to people, to deal more adequately with problems, to feel a sense of worth and well-being.

The houseparents or counselors are chosen for their healthy personality patterns, tolerance in living with deviate behavior, capacity to grow in theoretical knowledge and practical skills—and pleasure in seeing children grow. They take pleasure in seeing children grow but have sources of personal emotional support and enrichment outside the institution—rather than to depend entirely on the children and residential personnel for meeting their own emotional needs.

■ 16. *Staff are comfortable about the experimental nature of their human relationships, and their responsibility for re-examining, evaluating, and readjusting treatment methods in the light of objective findings.*

■ 17. *The various professional people in the institution are learning how to use their knowledge and skill in the residential setting.* (34, p. 50–61) For example psychiatrists new to this kind of group living are learning how to work with some of the inescapable interrelationships between individual diagnosis, treatment planning, and group living. Social workers are learning how to work closely with houseparents. ". . . The recommendations and treatment of the clinic can attain their full value only if carried out by people familiar with the dynamics of the institution and to so shape their recommendations as not to introduce impossible elements into an institutional situation." (2, p. 12)

■ 18. *The physical plant is shaped by the program, not the contrary.* Traditional architecture is yielding to more functional building based on what children need. There is experimentation with decentralized units such as group homes or expanded foster family homes or detached units for selected groups of children.

■ 19. *Smaller units or in some instances larger institutions are being located in urban or suburban areas.* Some of these units have enough physical separation from neighbors to permit a broad range of behavior without neighborhood censure, but close enough to make use of community clinical, educational and recreational facilities. Parents are closer, too, to children. So are agency workers, medical and clinical staff, and qualified full- or part-time staff who prefer to live in their own communities.

■ 20. *And finally, institutions are moving away from the cold, antiseptic feeling and are creating a warm, hopeful, personal and good-humored atmosphere which has unique treatment values of its own.*

referring agencies, courts, and clinics

What implications do these changing conditions, knowledge, and resources have for community agencies referring children for care in institutions? The outstanding implication is for sharper differentiation of children's needs and differentiation of what individual institutions can offer to meet these. ***Agencies recognize that no two children are alike. But they also need to recognize that no two foster families or institutions are alike in what they***

offer the child. Referring agencies must know what the child needs, what his family can or cannot provide with agency help, what the pressures of the neighborhood are, and what specific foster families and institutions can provide in relation to the child's needs and his family situation.

Whenever possible a child should be helped at home through full use of community resources for the child and his family. If resources are lacking, referring agencies have a responsibility for helping to promote such resources. But, when a child can no longer be cared for or helped in his own family, the referring agency has the difficult job of selecting the best available resource to meet the child's needs as well as to consider his parents' preferences. As mentioned earlier, skillful casework interpretation can help parents accept resources which they might reject initially.

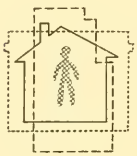
Neither the foster family nor the institution should be used on a routine basis for all children. Nor should they be used without study of their specific values and limitations for a particular child. The agency that prides itself on the adequacy of its foster family or adoptive home study before placement ought to examine the adequacy of its study of individual houseparents, professional services, and group influences in an institution it has chosen for a child.

The referring agency should know, for instance, if a particular institution provides custodial care only. Is the institution warm and generally supportive, or will it be cold, impersonal and deadening for the particular child to be referred? Does another institution provide constructive group influences for outgoing youngsters but miss entirely the withdrawn child who needs gradual introduction into group activities? Can it help a child who is so disturbed inwardly that he may need much individual treatment and support before he can constructively utilize group activities?

No child should be referred or committed to an institution with which the caseworker, probation officer, or judge is unfamiliar. ***Placement alone is not necessarily sound treatment.*** It is merely physical removal of the child from one setting to another. The new setting may be psychologically helpful: or it may be hurtful. Placement can only be constructive when the child's needs and his family needs are identified, and the institution is used on a planful basis in response to these needs. While the child is away from home, his needs may change and this makes constant re-evaluation of the child and family essential. The referring agency and the institution, as they continue to work with the family, have a responsibility for determining when the family and child are ready to resume living with each other, or whether some other placement is indicated.

Even though a child must leave his community for care, the

"base" for total planning should generally remain with a community agency familiar with developments in the child, the family, and community. ***The institution is an interim not a terminal resource.*** A child should not be placed in an institution as an "act of last resort but rather of established purpose." (12, p. 181.) And no child should be fatalistically referred for permanent custodial care, even though he has severe limitations. The director of a large public institution for retarded youngsters says, "I don't think anyone on the face of the earth knows what the ceiling of a child is. We need a lot of research to find out, and to develop techniques to meet special needs." (8, p. 155.)



community planning: immediate and long range

Community planning groups recognize that most institutions find it very difficult to take first steps toward participation in broader community planning for children. The institution's board members contributors, executives, and staff raise many questions. Will the community planning group try to take over the institution? Can they be trusted? Who will decide which children need care most in the community? What will we have to give up? What will we be asked to take on? Do we have the knowledge and skill to take on a new function?

The institution needs reassurance. Its sponsors need to feel they will have a significant voice in deliberations regarding needs, goals, priorities, and assumption of new service responsibilities. They need to feel there is an objective, fair-minded planning group which is interested not only in the welfare of children but also in the best future for each participating institution or organization. And they need to know that certain institutions for certain kinds of children outlive their usefulness. But other institutional or noninstitutional services for children are very much needed in most communities.

Conversely, for the community, it is mature, far-sighted planning groups that are beginning to advance the total base of services for youngsters. Each community has its own way of discovering leaders for such planning groups. Each has its own methods for

studying need, determining objectives, enlisting support, and acting to establish services.

Obstacles to planning

Some common obstacles confronting community groups planning services for children include:

1. Lack of organized ways of identifying children early who need help, especially preschool children.
2. Too much "disposition of child before adequate diagnosis" of his needs.
3. Too much focus on the child alone, with insufficient understanding of the importance of working with parents, and community influences bearing on the child.
4. Too much segmental, independent development of child-caring services, with isolation and lack of communication between public and voluntary child-caring organizations.
5. A hampering philosophy of preserving and protecting present-day organizations, rather than promoting the best possible care for children in need, even if this calls for modification of present-day organizations.
6. Tremendous sums of money spent annually on services whose effects are rarely subjected to test or evaluation.
7. Lack of basic facts and basic research tools to evaluate the effects of service. Lack of concurrence on theoretical conceptions that could be useful in promoting evaluation of basic research in child development and child care.
8. Lack of long-range objectives to guide immediate action in developing services.
9. Inadequate use of community planning and development groups.
10. Planning controlled by small segments of population or small agency or council groups, rather than shared broadly with the public, and with key civic, religious, and business groups in the community. Insufficient participation of public agencies and institutions in community wide planning.

Recent gains

Despite such obstacles, planning groups have made substantial gains recently in promoting broader planning for children's services. These include: increased communication and cooperation among agencies and institutions, greater attention to unserved as well as served children, and improved communication between various professions in

social welfare, health, including mental health, and education programs.

More specifically, gains are being made in reaching children and families earlier, before deviations have endured and deepened over several years. For instance, in one eastern city, several therapeutic day-nursery programs are trying to reach disturbed children and their families before the youngster reaches school age. At the same time public schools are working with welfare and mental health services to identify school-age disturbed children in the early grades (32). In addition, a long-range research effort is attempting to identify specific parental and family relationships which tend to produce disturbance and delinquency in school-age children.

These are the kinds of efforts that need the support and help of community planning groups.

Several steps are being taken to modify the problem of "too much disposition before diagnosis"—children abruptly removed from their families and placed in foster family or institutional care without adequate diagnosis of the child, family, and community influences. For example, a midwest child-placing agency has abandoned its use of an institutional study home as the agency's caseworkers gained skill in diagnostically evaluating children in their own homes or foster homes. In at least 10 States, courts are committing retarded or delinquent children to commissions or reception centers on a limited basis for study and treatment according to their needs. Many public and voluntary institutions are asking community agencies to study children and their families before institutional care is assumed to be the appropriate service.

Inventory of services

However, community planning groups ought to recognize that as diagnostic facilities improve, more differentiated treatment programs will be essential. This is often the catalyst that moves planning groups to do an inventory of all the services needed. One effort of this kind is the 10-point program recommended by a national planning and coordinating group for retarded children (22, p. 41).

1. A network of community diagnostic-treatment clinics with professional counseling for parents.
2. Home counselors to help parents in training the infant and child in the home.
3. Nursery classes, with normal children whenever possible; special nursery classes and day-care centers for the more severely retarded.

4. Special education with improved vocational training for the "educable" child.

5. Special education with improved social training for the "trainable" child.

6. Vocational training centers and sheltered workshops, including personal adjustment training and terminal employment.

7. Community centers with recreational, social, and counseling facilities for the adolescent and adult retarded who are dependent and cannot be integrated into the facilities for normal people.

8. Integration of the "marginally independent" retarded in society, including vocational rehabilitation and selective placement in regular employment.

9. Dynamic, community-minded residence centers or institutions. . . .

10. Research and professional training.

The long view

Long-range objectives become clear when all the pieces are laid out this way. Many planners believe that sound progress in developing services for children means developing services in logical succession—preventive before diagnostic, diagnostic before treatment, community treatment before foster family or institutional care, etc. This "logical" succession is based on the belief that services which reach large numbers of children at earlier ages or stages of disturbance are generally less expensive, shorter-termed, and have more favorable outcomes than those which reach children later in more deeply handicapping conditions. This sequence should be kept in mind, even when a strong group in the community moves rapidly to promote, for example, a residential diagnostic facility long before community diagnostic and treatment resources are developed.

Occasionally, a community planning group will find it strategic to go ahead with a small institution in an effort to spark real understanding of the need for other services. But such a planning group must recognize that the best child-caring institution is never the "solution" for disturbed, delinquent, or retarded children. Once established, it can create more service problems than it resolves, unless it has a well defined and limited role in a total community plan. Standing alone, the institution has limited value. Integrated with preventive, diagnostic, and community treatment resources, it assumes much greater value for troubled children and their community.

This group should be helped to recognize that as it goes ahead with the resident facility, it has a serious obligation to help promote community preventive, diagnostic, and treatment facilities. It

may find the value of its "diagnostic prescription" meaningless unless there are treatment resources in the community to fill the prescription.

Through sound community study and action, the development of long-range service objectives can be achieved. With this in mind, the United Community Services in Savannah, Georgia, is promoting a Coordinating Council on Services to the Handicapped (33). The Council is intended to be a community-wide organization to take on the job of educating the public to the needs of the troubled, retarded, and handicapped individuals and to the services available in the community, State, region and nation. It "should provide the means for continuous self-appraisal of the community toward an economical, efficient, and comprehensive program for people with handicaps and disabilities." It proposes for itself seven essential methods which can apply to the children considered in this document:

1. An estimate of the extent of the need of various services for the handicapped and disabled.
2. Information to the community of desirable procedures for planning and programing.
3. An evaluation of current programs.
4. Discovering what new programs are needed.
5. Finding out what can be done immediately to strengthen programs.
6. Recommendations on what can be done in the next few years to extend current programs and develop new ones, and
7. Development of a ten-year plan to serve the entire needs of the groups of children under consideration.

Five other considerations are involved in developing services for children.

First, need persists for much more basic research—new knowledge—on the development of children and the effects of dependency, emotional disturbance, delinquency and retardation in their lives. Along with this must go research evaluating current methods of helping children, especially comparisons of alternative methods of discovering, diagnosing, and treating children's deviations. So much of our help to youngsters is still of untested experimental nature. We need more than a consensus of the best prevailing professional opinions regarding theoretical concepts as well as practice. And we need better application of knowledge we already have.

Second, evaluation of results should be studied in terms of financial investment involved. Is it wiser to send certain preschool retarded children, for example, to a State residential school at a cost of

at least $1,500 annually when some of these children can be served at home with counseling for their parents at much less expense? And perhaps better results for many? Conversely, is it wise to try less expensive foster family care for a child who really needs good quality residential care with appropriate services?

Third, local communities need to encourage and request regional, Statewide, and national cooperation in studying and developing services for children. On the State level, unresolved questions of public-voluntary financing exist, the problem of bringing services to rural areas, and the need for Statewide coordinating bodies persist. One State reports that " . . . one of our biggest headaches is the Statewide child-caring institution. They are somewhat related to the city in or near which they are located, if any, but cannot relate to all of the cities they serve. They do not make good use of the social services in distant cities, where available, and cannot provide these services themselves through their own staff. On the other hand, if there were good community planning in these cities, they would not be getting the referrals from them that they do."

Fourth, State licensing programs need to be strengthened. In some States they are excellent resources for child-placing agencies and institutions. Such programs protect children from sub-marginal care. They promote better standards of care for all facilities, relate individual organizations to community coordinating groups, and serve as a clearinghouse for information, research, and program activities. Adequate standards need to be developed for institutions serving disturbed children and for institutions serving retarded children.

Fifth, national voluntary and public agencies have a heavy responsibility in all this. They need to examine the major changes in society which are affecting families and communities and creating greater demand for services for children. They need to appraise the results of experiment and practice and report upon them for the benefit of all child-caring organizations and planning groups. Guides and standards based on such critical evaluation as well as on the best prevailing professional opinions are essential.

For over two centuries, citizens have been concerned with the troubled child and his family. Civic leaders and volunteers were the first to reach out and help. Then came the professional worker. And present day partnership is beginning to encompass the social scientist, research consultant, and community planner—along with the supporting citizen and contributor, the parent, volunteer, professional worker, and legislator.

There is still much to be done, but all that has been done augurs well for children and their families in the future.

references

(1) American Psychiatric Association: *Psychiatric Inpatient Treatment of Children.* Washington, D. C.: American Psychiatric Association, 1957. 194 pp.

(2) American Psychiatric Association: *Training Schools for Delinquent Children: A Guide to Planning with Particular Reference to Clinical Facilities.* Washington, D. C.: American Psychiatric Association, 1952. 22 pp.

(3) American Public Health Association: *Services for Handicapped Children, A Guide to General Principles and Practices for Public Health Personnel.* New York: American Public Health Association, 1955. 148 pp.

(4) Bowlby, John: *Maternal Care and Mental Health.* New York: Columbia University Press, 1951. 179 pp.

(5) Bureau of the Census, U. S. Department of Commerce: *Children Under Institutional Care and in Foster Homes—1933.* Washington, D. C.: U. S. Government Printing Office, 1935. 125 pp.

(6) Bureau of the Census, U. S. Department of Commerce: *United States Census of Population: 1950; Special Reports—Institutional Population.* Washington, D. C.: U. S. Government Printing Office, 1953. 211 pp.

(7) California Youth Authority: *Guide for Court Investigations and Reports.* Sacramento, California: California Youth Authority, 1955. 26 pp. (p. 12–17).

(8) Capa, Cornel and Pines, Maya: *Retarded Children Can Be Helped.* Great Neck, New York: Channel Press, 1957. 160 pp.

(9) Child Welfare Board of Summit County: *The 1957 Needs of Summit County's Dependent and Neglected Children.* Akron: Child Welfare Board of Summit County, March 1957.

(10) Cianci, Vincentz: Home Supervision of the Mental Deficient. *American Journal of Mental Deficiency,* 1947, 51, 519–524 (January).

(11) Cohen, Albert K.: *Delinquent Boys: The Culture of the Gang.* Glencoe, Illinois: The Free Press, 1955. 198 pp.

(12) Cohen, Frank J.: *Children in Trouble: An Experiment in Institutional Child Care.* New York: Norton, 1952. 252 pp.

(13) Department of Institutions and Agencies: *Highfields Experimental Treatment Project for Youthful Offenders.* Hopewell, New Jersey: (No date) 68 pp. (Mimeographed).

(14) Elizabeth McCormick Memorial Fund: Proceedings of the Conference on Research in the Children's Field. *Social Service Review,* 1956, 30, 237–357 (September).

(15) Glickman, Esther: *Child Placement Through Clinically Oriented Casework.* New York: Columbia University Press, 1957. 448 pp. (Chapter 1.)

(16) Hagan, Helen: *The Institution as a Casework Agency.* New York: Child Welfare League of America, 1954. 25 pp.

(17) Hill, Esther P.: Is Foster Care the Answer? *Public Welfare*, 1957, 15, 67–72 (April).

(18) Illinois Department of Public Welfare: *Report of Survey of State and Territorial Facilities and Programs for Mentally Ill and Emotionally Disturbed Children.* Chicago, Illinois: State Department of Public Welfare, Institute for Juvenile Research, December 1956. 56 pp.

(19) Kline, Draza B.: Should Children Be Separated from Their Parents? *The Child*, 1953, 17, 71–74 (January).

(20) Konopka, Gisela: *Group Work in the Institution—A Modern Challenge.* New York: William Morrow and Company, 1954. 304 pp.

(21) Muroff, Melvin; Cadman, William; Averill, Stuart; and others: *A Conceptual Framework for the Residential Treatment of Delinquents.* Topeka: Boys Industrial School, 1957. 16 pp.

(22) National Association for Retarded Children: Proposals on a Federal Program of Action in 1956–57 for America's Mentally Retarded Children and Adults. Quoted in *New Directions for Mentally Retarded Children.* New York: Josiah Macy, Jr., Foundation, 1956. 171 pp.

(23) Perlman, Helen Harris: The Client's Treatability. *Social Work*, 1956, 1, 32–40 (October).

(24) Reid, Joseph and Hagan, Helen: *Residential Treatment of Emotionally Disturbed Children—A Descriptive Study.* New York: Child Welfare League of America, 1952. 313 pp.

(25) Roselle, Ernest: New Horizons for the Mentally Retarded When a State Looks at the Problems as a Whole. *American Journal of Mental Deficiency*, 1955, 59, 359–373 (January).

(26) Schudde, Louis O., and Epstein, Lenore A.: Orphanhood—A Diminishing Problem. *Social Security Bulletin*, 1955, 18, 17–19 (March).

(27) Sites, Walter, and Farrar, Marcella: *Toward Better Adjusted Children—Schools and Community Agencies Work Together.* Cleveland: Welfare Federation of Cleveland, October 1957. 72 pp.

(28) Social Planning Council of St. Louis: *A Study of Sixteen Children's Institutions in St. Louis and St. Louis County.* St. Louis: Social Planning Council, 1954. 88 pp.

(29) South Dakota Children's Home Society Newsletter, August 1957.

(30) Tarjan, George: What Hospitals for the Mentally Retarded Can Achieve. *Children*, 1956, 3, 95–101 (May–June).

(31) Ullman, Charles: *Identification of Maladjusted School Children: A Comparison of Three Methods of Screening.* Washington, D. C.: U. S. Government Printing Office, Public Health Publication No. 211, 1952. 42 pp.

(32) United Community Services: *Learning to Live.* Savannah, Georgia: United Community Services, 1956. 113 pp.

(33) U. S. Department of Health, Education, and Welfare, Children's Bureau: *Institutions Serving Delinquent Children—Guides and Goals.* Washington, D. C.: Government Printing Office, Children's Bureau Publication No. 360, 1957. 119 pp.

(34) U. S. Department of Health, Education, and Welfare, Office of Education: *Statistics of Special Education for Exceptional Children.* Washington, D. C.: Government Printing Office, 1952–53. 78 pp.

(35) Waskowitz, Verna: Foster-Family Care for Disturbed Children. *Children*, 1954, 1, 125–130 (July).

(36) Whelan, Ralph W.: *Reaching the Unreached: The Story of the New York City Youth Board.* New York: New York City Youth Board, 1954. 201 pp.

(37) Wildy, Lois: The Professional Foster Home. *Child Welfare*, 1955, 1–5 (January).

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